APPLICATIONS ACCESS FORM

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
PROVIDER SUPPORT OFFICE

REQUEST TYPE

Effective Date	☐ Add New User	☐ Update Information	☐ Add Reporting Unit ☐ Delete Reporting Unit	☐ Add Role ☐ Delete Role	☐ Termination ☐ Name Change
Transfer ☐	From Location		To Location		

EMPLOYEE STATUS

☐ Permanent ☐ Temporary ☐ Pharmacy ☐ FFS ☐ MHSA ☐ NGA ☐ DHS

APPLICATION INFORMATION

Employee No. (County Only)	Last Name	First Name	MI	Last 4 Digits of SSN	
Date of Birth MM/DD	Sex Code	Ethnicity Code	Handicap Code	Language Code	Name of Facility/Bureau/FFS Network Provider/Pharmacy
Program Name/Unit	Address	Suite/Floor			
City	State	Zip Code	Phone Number	E-Mail Address	

ROLE(S) ☐ ☐ ☐ ☐ ☐ ☐

SELECT CLASS CODE & AUTHORIZED PROVIDER NO.

☐ DMH Provider No. ☐ ☐ ☐	☐ NGA Legal Entity No.
☐ DHS Provider No. ☐ ☐ ☐	☐ FFS Provider No. **(*)**

SELECT APPLICATION ACCESS

☐ Integrated System	☐ Day Treatment Authorization	☐ STAR	☐ MAA	☐ PRM	☐ **Provider Connect**

Oath of Confidentiality on File at Facility ☐

SIGNATURES

Applicant Name	Signature	Date Completed
Contact (Print Name)	Phone Number	Date Completed
Program Head/Authorized Designee (Print Name)	Signature	Date Completed

FOR PSO USE ONLY

User ID	HEAT Call Ticket	Date Received
Processed By	Remarks	Date Completed

Having problems filling out this form? Call CIOB Helpdesk at (213)351-1335 (Revised 10/06/2013) Please Return to: Department of Mental Health
PSO – Systems Access
695 S Vermont Ave.
Los Angeles, CA. 90005

(*) Please use Form MH1003 for additional location.